

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>150126</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>12/01/2011</b>
NAME OF PROVIDER OR SUPPLIER  <b>FRANCISCAN ST ANTHONY HEALTH - CROWN POIN1</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>1201 S MAIN ST CROWN POINT, IN 46307</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	<p>INITIAL COMMENTS</p> <p>This visit was for investigation of a state licensure hospital complaint.</p> <p>Complaint Number: IN00090049</p> <p>Unsubstantiated: No deficiencies cited.</p> <p>Date: 12/1/11</p> <p>Facility Number: 005107</p> <p>Surveyor: Jacqueline Brown, R.N., Public Health Nurse Surveyor</p> <p>Community Hospital is in compliance with 410 IAC 15-1.6-2, Emergency services, and 410 IAC 15-1.5-5, Medical staff, Indiana Hospital Licensure Rules.</p> <p>QA: cloughlin 12/21/11</p>	S 000		

Indiana State Department of Health

TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATE FORM

6899

VJE711

If continuation sheet 1 of 1